

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER 01-05	2. STATE: ILLINOIS
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: January 1, 2001	

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN

☒ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT a. FFY 01 \$ 0 b. FFY 02 \$ 0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A Page 1 Attachment 3.1-B Page 1	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 3.1-A Page 1 Attachment 3.1-B Page 1

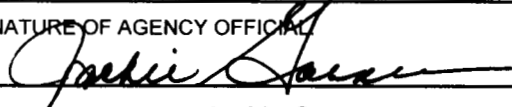
10. SUBJECT OF AMENDMENT:

Inpatient Hospital


11. GOVERNOR'S REVIEW (Check One)

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:
Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL 	16. RETURN TO: ILLINOIS DEPARTMENT OF PUBLIC AID 201 SOUTH GRAND AVENUE, EAST SPRINGFIELD, IL. 62763-0001 ATTENTION: John Rupcich
13. TYPED NAME: Jackie Garner	
14. TITLE: DIRECTOR	
15. DATE SUBMITTED	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 3/30/01	18. DATE APPROVED: 4/4/01
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1/1/01	20. SIGNATURE OF REGIONAL OFFICIAL 
21. TYPED NAME: Cheryl A. Harris	22. TITLE: Regional Administrator
23. REMARKS: RECEIVED REGIONAL ADMINISTRATOR MAR 30 2001 DMCH - IL/IN/CA	

State Illinois

1. INPATIENT HOSPITAL SERVICES (OTHER THAN THOSE PROVIDED IN AN INSTITUTION FOR MENTAL DISEASES OR TUBERCULOSIS)

- Certain inpatient hospital services are subject to review by the Department's Peer Review Organization and will not be covered unless medical necessity is shown and documented. At least thirty days prior to the effective date, ~~each hospital is~~ is notified of changes to review requirements ~~applicable to the individual hospital through official Departmental letters via certified mail, return receipt requested.~~ Statewide hospital review requirements are specified in the Department's provider manuals and/or notices.
- Preoperative days will be limited to only the day immediately preceding surgery unless the attending physician provides documentation demonstrating the medical necessity of an additional day or days.
- ~~All~~ Inpatient psychiatric services are subject to a review by the Department's Peer Review Organization. Only medically necessary inpatient psychiatric care will be approved.
- Limits on services or treatments are not applicable to EPSDT (Healthy Kids) clients. All services or treatments which are medically necessary to correct or lessen health problems detected or suspected by the screening process must be provided to individuals under age 21.

2. OUTPATIENT HOSPITAL SERVICES

Most outpatient hospital services provided are covered utilizing specific fee-for-service codes. Utilization control, e.g., prior approval policies which may apply to the service in question and which would be required of nonhospital providers rendering services on a fee-for-service basis, is in effect.

A Hospital Ambulatory Care list defines those technical procedures that routinely require the use of the hospital outpatient setting, its technical staff and/or equipment. This list is updated annually.

Client coverage policies applicable to those services provided under the policy used by nonhospital providers include any requirements for utilization control or prior approval as specified in Illinois Administrative Rule and Provider Handbooks.

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TN # 01-05
SUPERCEDES
TN # 91-12

APPROVAL DATE _____ Effective Date 1/01/01

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